NEW PALTZ MIDDLE SCHOOL

196 Main Street, New Paltz, New York 12561 • Phone: (845)256-4200 • Fax: (845)256-4209 • www.newpaltz.k12.ny.us

Dr. Richard Wiesenthal
Principal

Mrs. Ann Sheldon
Assistant Principal

May 2018

Dear Parent/Guardian of a 6th grader:

Our trip to Frost Valley is fast approaching. The dates are September 12, 13, and 14, 2018. Cost of the trip is $186.00 per student. Payment and designated forms for the trip are due by Friday, June 15, 2018. PLEASE MAKE YOUR CHECK PAYABLE TO: NEW PALTZ MIDDLE SCHOOL. **Please have your child return forms and monies to the Main Office at Lenape Elementary School OR New Paltz Middle School.**

Chaperoning- Last year, and for the past few years, we have had enormous parent interest in chaperoning. Several years ago we had over 40 parent chaperones, some staying for the entire trip while others stayed for parts of different days. In fact, we had too many parent chaperones. In groups of 12 students we had 2 teachers, a Frost Valley staff person and often 3-5 parents.

We will prioritize our needs regarding chaperones and get this information to parents as soon as possible. Highest priority will be given to those parents who are able to stay the entire 3 days. If we receive more applications than needed, we will put them in a hat and parent's names will be drawn at random. If we receive fewer than 12 applicants able to spend the 3 days, we will begin taking parents who can stay 2 days, 1 day, etc.

If you are interested in chaperoning, as noted above, we would love to have you join us. I have enclosed a chaperone form, which you will need to complete and return as soon as possible with your chaperone fee (chaperone fee is $200.00).

If you are requesting financial assistance, a copy of the financial assistance form is attached. Return with other designated forms and monies.

Please have the medication forms filled out promptly by your doctor. These forms can only be used for the Frost Valley field trip. Please note that the form includes both prescription and non-prescription medication. If your child requires special medical attention, please see our school nurse, Ms. Bush.

Included is a "Bring Along" list, as well as, a sample itinerary. Frost Valley will provide blankets and pillows for all attending. Students (and parents) will need to bring two sheets and a pillowcase. Please check the "Bring Along" list for other required items.

Phone access (students to call home) is quite limited. It is often difficult for students to call, as Frost Valley only has two pay phones and there is no cell phone service. If your child does not get a chance to call home, please understand. They will fill your weekend with what happened upon their return.

We look forward to an exciting and rewarding trip.

Sincerely,

Dr. Richard Wiesenthal
Principal

(MUST BE RETURNED)

New Paltz Middle School
Field Trip Permission Slip

I hereby give permission to allow________________________ to attend a field trip with the New Paltz Middle School to the **Frost Valley Environmental Education Center** on **September 12, 13, and 14, 2018.**

Departure from the Middle School will be on **Wednesday, September 12th at 9:00 A.M.** Students will **return** to the Middle School on **Friday, September 14th at 2:00 P.M.** All students **MUST** be picked up at the Middle School in the main parking lot.

Please indicate below whether your child will require any special medical attention during this trip. (**Check One:)**

___Yes, my child will require the following medical attention (please describe): Please contact the school nurse at 256-4210 if you have any questions.

____

____

___ No, my child will not require special medical attention.

________________________________ ____________________

Parent/Guardian Signature Date

RW/dt

(Return if Applicable)

FINANCIAL ASSISTANCE FORM

Parent Name ____

Student's Name ____
(please print)

Address ____

Phone Numbers: Home ____________________ **Work** ____________________

Frost Valley Trip Cost **$186.00**

Parent Contribution ________

Needs Assistance ________

____

TOTAL **$186.00**
=====

OFFICE USE ONLY

____

____

(parent copy)

NOTICE from the SCHOOL NURSE

Any student who needs to take medication during the Frost Valley field trip must have the correct and completed medication forms.

THIS INCLUDES BOTH PRESCRIPTION AND NON-PRESCRIPTION, OVER THE COUNTER MEDICINE (including, but not limited to: i.e.Tylenol, Advil, nasal sprays, allergy medication).

These forms can only be used for the Frost Valley field trip.

Should you have any questions, please contact Nurse Bush at 256-4210.

New Paltz
Central School District
196 Main Street, New Paltz, NY 12561

STUDENT MEDICATION PROCEDURES

When your child's physician feels that it is necessary for medication to be taken during the school day, there are certain procedures as mandated by the New York State Education Department which must be followed. School nurses **can not** administer any medication, including over the counter medicines, to students without a written order from a physician. This order must be signed by both the physician and you as the parent/guardian. Our procedures are as follows:

- **EACH SCHOOL YEAR**- At the beginning of each school year, a NEW, completed New Paltz Central School District Authorization for Medication Form must be presented to your child's school nurse. This form must be signed by both the physician and you as the parent/guardian.

- **MEDICATION**-
  - Must be delivered directly to the school nurse by the Parent or Guardian. You will be provided with a receipt for the medication. **NO** medication will be accepted from students.
  - Medication **MUST** be in the original labeled container as prepared by the pharmacist. Over the counter medications must be in the original packaging.
  - At the end of the school year medications must be picked up on the last day of school. Nurses by law are not permitted to keep medications over the summer. Medication can also not be returned to students.

- **STUDENTS AND SELF CARRY MEDICATIONS-** Certain medications may require a student to carry and administer their own medication. This is generally for medications requiring immediate administration such as inhalers or medication for allergic reactions. If it is necessary for your child to carry the medication, the child's physician **must** indicate that your child has been instructed in and understands the proper use of their medication on the New Paltz Central School District Authorization for Medication Form.

- **MEDICAL INFORMATION AND ACADEMICS**- Your child's health plays a part in their academic performance, including behavior and ability to concentrate. In order to help keep your child focused on their academics the nurses are asking permission to share relevant medical information with your child's teachers. To grant this permission please sign the related line on the New Paltz Central School District Authorization for Medication Form.

Incomplete forms will not be accepted

Permission to Administer Multiple Medications

Student Name: ______________________________ DOB: ______________

Grade: __________ Teacher/HR: ______________________ School: ______________

To Be Completed By Health Care Provider

Diagnoses ____

Medication Name	Dose	Route	Time	☑ applicable boxes below
				☐ AM ________ ☐ FT ☐Self-Directed ☐ Self Admin-Self Carry
				☐ AM ________ ☐ FT ☐Self-Directed ☐ Self Admin-Self Carry
				☐ AM ________ ☐ FT ☐Self-Directed ☐ Self Admin-Self Carry

Prescriber please use codes below for each medication ordered:

AM	Nurse may administer missed morning dose indicated after verbal or written notification from parent. Please advise parent to send in additional medication
FT	Medication is needed on field trips.
Self-Directed	I assess this student is self-directed regarding their medication. They understand the purpose, name, amount, dose, timing, and effect of taking or not taking the medication, can recognize the medication and refuse to take it inappropriately and can ingest, inhale, apply or calculate and administer the correct dose of the medication independently. NOTE: Must be evaluated/approved by building Nurse.
Self-Administer/ Self-Carry	I have determined this student is consistent and responsible in taking their own medications (Self-Directed) and in addition, give them permission to self- carry and self-administer this medication. They will be considered independent in medication delivery and need intervention only during emergencies. NOTE: Must be evaluated/approved by building Nurse.

Name and Title of Licensed Prescriber (Please Print) ______________________________

Prescriber's Signature ______________________ **Date** __________ **Phone** ______________

To Be Completed By Parent

I give permission for the above medication to be administered to my child as ordered by my health care provider. I will furnish the medication in the original pharmacy container, properly labeled with directions and dosage, or original over-the-counter medication container/packaging with my child's name on it. Please note that this information will be shared with School Personnel involved with your child.

Parent/Guardian Signature ______________________ **Date** __________ **Phone** ______________

Self-Administer/Self Carry

Parent permission and provider consent is required for students to self-administer and self-carry medication. Students with this designation are considered independent in taking their medication at school and require no supervision by the nurse. Parents assume responsibility for ensuring that their child is carrying and taking their medication as ordered. Schools may revoke the self-carry/ self-administer privilege if the student proves to be irresponsible or incapable. To request this option please sign below:

Parent/Guardian Signature ______________________ **Date** __________ **Phone** ______________

School Nurse: ______________________ School ______________________

Phone: ______________ Fax: ______________ Email ______________

FROST VALLEY YMCA GUENTHER FAMILY WELLNESS CENTER
2000 Frost Valley Road, Claryville, NY 12725
TEL 845-985-2291 ext. 225 **FAX** 845-985-0059 **WEB** frostvalley.org

STUDENT HEALTH FORM

DATE OF TRIP: FROM 9/12/18 TO 9/14/18
School NEW PALTZ MIDDLE SCHOOL Lead Teacher DR. RICHARD WIESENTHAL

A

Student Last Name ______________ **First Name** ______________
Parent/Guardian's Name ______________
Phone Number: (home) __________ (work) __________ (cell) __________
Home Address ______________
Family Physician ______________ Phone __________
Insurance Company ______________ ID# __________
In an emergency, if unable to reach parent, contact:
Name ______________ **Phone** __________
Name ______________ **Phone** __________

Health History: (please check all that apply and explain):

___Asthma	___Glasses/contact lenses	___Heart disease/defect
___Diabetes	___Eating disorders	___Nose bleeds
___Hypertension	___Respiratory disorder	___Ear infections
___Seizure disorder	___Sleep walking	___Chicken pox
___Headaches	___Bedwetting	___Other

Comments: ______________

Any known allergies (Food or Drug): ______________
Diet Restrictions ______________
Date of Last Tetanus Shot ______________

CUT WHEN NEEDED

Note: 2 signatures REQURIED* below

AUTHORIZATION TO CONSENT TO TREATMENT OF MINOR TEMPORARILY SEPARATED FROM HIS/HER PARENTS

B

I, the undersigned, parent or legal guardian of (child's name) ______________, a minor, am familiar with the program and the general nature of activities planned during their trip to Frost Valley YMCA, and to the best of my knowledge the above information is correct and my child is capable of participating in and has permission to engage in all activities. I do hereby authorize
(School Name) ______________
(Lead Teacher) ______________ As our agent(s) to consent to any diagnostic procedure or medical care which is deemed advisable by, and is to be rendered under the general or special supervision of any liscensed physician at the nearest hospital with facilities appropriate to my child's injury/illness. I agree to the release of any records necessary for medical treatment or insurance purposes. This authorization shall remain effective until (day after the last day of the trip)________ unless sooner revoked in writing delivered by said agent(s).
***Parent/Legal Guardian's Signature** ______________ **Date** __________

STUDENT WAIVER OF LIABILITY

C

I hereby accept any and all responsibility for, and assume the risk of any and all injury or damage to my dependent children which might arise directly or indirectly as a result of, and or participation in, the Frost Valley YMCA program. I hereby expressly release, discharge and hold harmless from any liability whatsoever the Frost Valley YMCA and all employees and volunteers in their capacities as representatives of the YMCA. Except for injuries caused intentionally, or by willful misconduct, I certify that I am familiar with the contents of this release, that I have read and understand the same, and that it is my intention by signing this release that the same is binding not only of me, but my heirs, administrators, executors, successors and assigns. This document may be photocopied.
***Parent/Legal Guardian's Signature** ______________ **Date** __________

D

STUDENT MODEL AND STATEMENT RELEASE

Periodically, Frost Valley YMCA uses photos and statements made by participants in Frost Valley YMCA programs for newsletters, fundraising efforts, brochures and articles about Frost Valley YMCA. All photos and statements are used with reasonable judgement for purposes directly relating to the operations of Frost Valley YMCA. This signed form gives Frost Valley YMCA permission by the signer to utilize participant photos or statements for the purposes mentioned above.
Parent/Legal Guardian's Signature ______________ **Date** __________

Frost Valley YMCA Guenther Family Wellness Center

Written Physician & Parent Permission Form

2000 Frost Valley Road, Claryville, NY 12725 **Tel:** 845.985.2291 **Fax:** 845.985.0059

STUDENT NAME: ____________________ **DATE OF BIRTH:** ____________

SCHOOL NAME: ____________________

PHYSICIAN'S NAME: ____________________ **PHONE:** ____________

The following overy they counter medications are available at the Wellness Center, and can be administered as needed per label instructions by age and weight of the student. **PLEASE NOTE:** Absolutely **NO** overy they counter or prescription medications, supplements, vitamins, or topical ointments can be administered without a physician and parent's signature , in accordance with New York State Education Law, Title 139, Section 6902.

ALL MEDICATIONS SENT TO CAMP MUST BE SENT IN THEIR ORIGINAL CONTAINERS WITH LABELING INTACT

TO THE PROVIDER: Please, indicate approval for administration by circling yes or no in the space indicated.

MEDICATION	ROUTE	DOSAGE	SCHEDULE & INDICATIONS	MAY BE ADMINISTERED
Tylenol (Acetaminophen)	By mouth (elixir or tablets)	Per label instructions By age and weight	Every 4 hours PRN pain or fever > _____°F	Yes No
Motrin (Ibuprofen)	By mouth (elixir, suspension or tablets)	Per label instructions By age and weight	Every 4 hours PRN pain or fever > _____°F	Yes No
Phenylephrine HCl	By mouth (tablets)	Per label instructions By age and weight	Every 4 hours PRN nasal congestion	Yes No
Robitussin (Guaifenesin)	By mouth (syrup)	Per label instructions	Every 4 hours PRN cough	Yes No
Dramamine (Dimenhydrinate)	By mouth (chewable tabs or tablets)	Per label instructions By age and weight	Every 6 hours PRN motion sickness	Yes No
Benadryl (Diphenhydramine)	By mouth (elixir, tablets or capsules) Apply topically	Per label instructions By age and weight	Every 6 hours PRN allergies, or insect bites	Yes No
Claritin (Loratadine)	By mouth (tablets)	10 mg	Daily PRN allergy symptoms	Yes No
Zyrtec (Cetirizine HCl)	By mouth (tablets)	10 mg	Daily PRN allergy symptoms	Yes No
Allegra (Fexofenadine)	By mouth (tablets)	180 mg	Daily PRN allergy symptoms	Yes No
Tums (Calcium Carbonate)	By mouth (tablets)	840 mg	Every 2 hours PRN acid indigestion	Yes No
Imodium	By mouth (tabs or capsules)	Per label instructions	After loose stools	Yes No
Lactaid (Lactase)	By mouth (caplets)	Three caplets	With first bite of dairy	Yes No
Maalox	By mouth (suspension)	10 mL	Every 4 hours PRN upset stomach	Yes No
Sunblock or Sunscreen	Apply topically	SPF ≥30	Apply PRN prior to sun exposure	Yes No
Insect Repellant	Apply topically	Aerosol or pump	Per label instructions	Yes No
Bacitracin Ointment	Apply topically	Bacitracin Zinc 500 U	Apply 1-3x Daily PRN minor cuts	Yes No
Hydrocortisone Cream 1%	Apply topically	Hydrocortisone 1%	Apply 3-4x Daily PRN skin irritation	Yes No
Antifungal Cream	Apply topically	Tolnaftate 1%	Apply twice daily to soothe itching	Yes No
Calamine Lotion	Apply topically	Per label instructions	As needed PRN itching	Yes No

PROVIDER: Please document below the current medication regimen for the above-stated student, including scheduled and PRN medications.

MEDICATION	ROUTE	DOSAGE	SCHEDULE	COMMENTS

The above-stated student may self-carry the following items and/or medications (select all that apply):

❑ Sunblock ❑ Epi-Pen ❑ Albuterol Inhaler ❑ Proventil Inhaler ❑ Insulin Pump Pens ❑ Other: ____________

The above noted "self-carry" items/medications are permitted for the indicated minor at all times. He/she has been instructed by the physician and acknowledges the proper understanding of the purpose, frequency, and appropriate method of use of these items and/or medications. As I consider him/her responsible, I will not hold Frost Valley YMCA personnel responsible for any errors which may arise in my child's self administration of these items and/or medications.

Physician/Healthcare Provider Signature: ____________________

Parent/Guardian Signature: ____________________ **Date:** ____________

(return if applicable)

FROST VALLEY 2018 ** * PARENT CHAPERONE

Parent Name ______________________________ Child ______________________
(please print) (please print)

____ YES, I would be interested in accommodations for all 3 days ($200).

____ I have more questions and would like to be called.

Phone Number _________________________

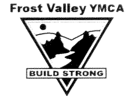
Parents play a vital role in our Frost Valley trip. Please consider being a chaperone. We guarantee your experiences will be enjoyable and memorable!

OFFICE USE ONLY

____

____

FROST VALLEY YMCA GUENTHER FAMILY WELLNESS CENTER
2000 Frost Valley Road, Claryville, NY 12725
TEL 845-985-2291 ext. 225 **FAX** 845-985-0059 **WEB** frostvalley.org



SCHOOL REPRESENTATIVE HEALTH FORM

(Teachers, Administrators, Chaperones and Parents)

School ________________________ **Lead Teacher** ________________________

Last Name ________________________ **First Name** ________________________

Date of Birth: ________________________

Phone number: (home) ________________ (work) ________________ (cell) ________________

Home Address ____

Family Physician ____

In an emergency contact:

Name ____ Phone ________________

Health History (please check all that apply and explain):

___Asthma	___Glasses/contact lenses	___Heart disease/defect
___Diabetes	___Eating disorders	___Nose bleeds
___Hypertension	___Respiratory disorder	___Ear infections
___Seizure disorder	___Sleep walking	___Chicken pox
___Headaches		___Other

Comments: ____

____

____

____

____

Any known allergies (Food or Drug): ________________________________

Diet Restrictions ____

Date of Last Tetanus Shot ________________________

Please indicate all prescribed and over the counter medications currently taking:

Medication	Dosage	Time	Comments

I am familiar with the program and the general nature of activities planned during the trip to Frost Valley YMCA, and to the best of my knowledge the above information is correct and I am capable of participating in all facility activities.

Signature ____ Date ________________

CHAPERONE WAIVER OF LIABILITY

I hereby accept any and all responsibility for, and assume the risk of any and all injury or damage to my person which might arise directly or indirectly as a result of, and or participation in the Frost Valley YMCA program. I hereby expressly release, discharge and hold harmless from any liability whatsoever the Frost Valley YMCA program and all employees and volunteers in their capacities as representatives of the YMCA. Except for injuries caused intentionally, or by willful misconduct, I certify that I am familiar with the contents of this release, that I have read and understand the same, and that it is my intention by signing this release that the same is binding not only of me, but my heirs, administrators, executors, successors and assigns.

Signature ____ Date ________________

CHAPERONE MODEL AND STATEMENT RELEASE

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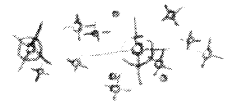
Signature ____ Date ________________

SCHOOL TRIPS PACKING LIST



NOTE: Students should be limited to ONE suitcase or duffle bag.
ALL ITEMS SHOULD BE MARKED WITH YOUR NAME.

☑ Use the handy list below to check off items as you pack them both at home before you come to Frost Valley YMCA and use it again to make sure you don't leave anything behind!

NECESSARY:

AT HOME	AT FROST VALLEY	
☐	☐	4 pairs of underwear
☐	☐	4 pairs of socks
☐	☐	pajamas
☐	☐	2 pairs of walking shoes
☐	☐	raincoat
☐	☐	hat or hood
☐	☐	2 warm pants or jeans
☐	☐	1 jacket
☐	☐	1 heavy sweater
☐	☐	warm shirts
☐	☐	light shirts
☐	☐	bath towel
☐	☐	tissues
☐	☐	soap, shampoo
☐	☐	comb or brush
☐	☐	toothbrush & toothpaste
☐	☐	sleeping bag
☐	☐	water bottle
☐	☐	backpack
☐	☐	pillow
☐	☐	flashlight

OPTIONAL:

AT HOME	AT FROST VALLEY	
☐	☐	slippers
☐	☐	reading materials
☐	☐	writing materials
☐	☐	plastic bags
☐	☐	waterproof boots
☐	☐	wash cloth
☐	☐	binoculars
☐	☐	sunglasses
☐	☐	lip balm/ chap stick
☐	☐	stamps
☐	☐	camera
☐	☐	laundry bag

WINTER GEAR:

AT HOME	AT FROST VALLEY	
☐	☐	snow pants
☐	☐	boots (insulated, waterproof)
☐	☐	2 pairs warm mittens/gloves
☐	☐	scarf
☐	☐	winter coat (insulated, waterproof)
☐	☐	2 pairs extra wool/warm socks
☐	☐	ski hat (must cover ears)
☐	☐	long underwear

* SNEAKERS ARE DISCOURAGED FOR WINTER WEAR

NOT ALLOWED:

- radio/CD player/MP3/MP4 player
- portable TV
- cell phones
- videogames
- knives
- candy or gum
- food
- hair driers
- fireworks
- matches
- pets

FROST VALLEY YMCA
2000 Frost Valley Road, Claryville, NY 12725
TEL 845-985-2291 FAX 845-985-0056 WEB frostvalley.org